

Please send completed form to either:

Fax: 02 8088 4384

Email: steppingon@royalrehab.com.au



Stepping  
On

## Stepping On - Registration Form

First name: _____ Surname: _____		
Address: _____		
Suburb: _____		Postcode: _____
Home phone: _____		Mobile: _____
Email: _____		
DOB: _____	Gender: Male	Female
Are you of Aboriginal or Torres Strait Islander origin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you looking after anyone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>How did you find out about the program? (select only one answer)</b>		
<input type="checkbox"/> Referred by other healthcare professional	<input type="checkbox"/> Referred by GP	
<input type="checkbox"/> Saw newspaper or newsletter article	<input type="checkbox"/> Saw poster or brochure	
<input type="checkbox"/> Recommendation by previous participant	<input type="checkbox"/> Other _____	
<b>ENTRY CRITERIA CHECKLIST – please answer all questions</b>		
<b>1. Falls History</b>		
1.1. Have you had a fall in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1.2. Are you concerned about falling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>2. Mobility Status - Can you walk independently or use a stick (without assistance of another person)</b>		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>3. Do you have a progressive neurological condition? (affects the brain, spinal column or nerves) e.g. Parkinson's, dementia</b>		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>4. Medical condition – Can you do gentle exercises?</b>		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>5. Do you live in the community or in an independent living unit?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>6. Are you registered with My Aged Care? (<a href="http://www.myagedcare.gov.au">www.myagedcare.gov.au</a>)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>7. Can you attend an English speaking group</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.1 If No, what language _____		
Emergency Contact: _____ Relationship: _____		
Contact Number(s): _____		
GP's name / practice: _____		
GP's address: _____		
Do you consent to us sharing information with your GP, during or upon your completion of the program?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>NB.</b> Your details will be entered into our database. When there is space in a group near you, we will contact you, please bear in mind that this can take some time.		
Some exclusion criteria may apply.		
<b>Additional Information</b> e.g. days not available, holidays planned:		
<b>OFFICE USE ONLY</b>		
Date Received:		